Nottinghamshire County Council

Public Health Sub-Committee

Thursday, 18 July 2013 at 14:00

County Hall, County Hall, West Bridgford, Nottingham NG2 7QP

1	**Minutes of the last meeting held on 6 June 2013** Details	**3 - 6**
2	**Apologies for Absence** Details	**1-2**
3	**Declarations of Interests by Members and Officers:- (see note below)** (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	**1-2**
4	**Integrated Commissioning Arrangements for Children's Health Services** Details	**7 - 22**
5	**Use of Public Health Grant to Address Community Safety and Violence Prevention** Details	**23 - 28**
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Nottinghamshire County Council

minutes

Meeting	PUBLIC HEALTH SUB-COMMITTEE
Date	6 June 2013 (commencing at 2.00 pm)

Membership
Persons absent are marked with `A'

COUNCILLORS

Joyce Bosnjak (Chair)
Glynn Gilfoyle (Vice-Chair)
Steve Carroll
John Cottee
Kay Cutts
John Knight
Martin Suthers OBE
Muriel Weisz
Jacky Williams

A Ex-officio (non-voting): Councillor Alan Rhodes

OFFICERS IN ATTENDANCE

Barbara Brady, Public Health Consultant
Tracy Burton, Senior Public Health Manager
Paul Davies, Democratic Services Officer
Dr Chris Kenny, Director of Public Health
Lindsay Price, Senior Public Health Manager
Anne Pridgeon, Public Health
Cathy Quinn, Associate Director of Public Health

CHAIR AND VICE-CHAIR

The appointment by the County Council of Councillor Joyce Bosnjak as Chair and Councillor Glynn Gilfoyle as Vice-Chair was noted.

MINUTES

The minutes of the last meeting held on 16 April 2013 were confirmed and signed by the Chair.

DECLARATIONS OF INTEREST

There were no declarations of interest.

MEMBERSHIP AND TERMS OF REFERENCE

It was reported that for this meeting only, Councillors Carroll and Cottee had been appointed in place of Councillors Rhodes and Adair.

RESOLVED: 2013/13

That the Sub-Committee's membership and terms of reference be noted.

PRESENTATION ON HEALTH AND SOCIAL CARE ACT 2012 AND PUBLIC HEALTH REFORMS

Dr Chris Kenny gave a presentation on the Act and Public Health reforms, and responded to questions from sub-committee members.

RESOLVED: 2013/014

That the presentation be received.

HEALTH AND WELLBEING INTEGRATED LIFESTYLE SERVICE

RESOLVED: 2013/015

That approval be given to the establishment of a project to explore the development of an Integrated Lifestyle/Wellness Service for Nottinghamshire.

USE OF PUBLIC HEALTH GRANT TO COMMISSION COMPREHENSIVE SEXUAL HEALTH SERVICES IN NOTTINGHAMSHIRE

RESOLVED: 2013/016

That £507,000 be released from the ring-fenced Public Health Grant to enable the current gaps in the Nottinghamshire Comprehensive Sexual Health Services to be addressed and the Public Outcomes Framework Indicators to be achieved.

RESOURCE FROM PUBLIC HEALTH GRANT TO FUND GAPS IN NOTTINGHAMSHIRE PREVENTION AND MANAGEMENT OF EXCESS WEIGHT PATHWAY

RESOLVED: 2013/017

That £540,000 be released from the ring-fenced Public Health Grant to enable the current gaps in the Nottinghamshire Weight Management Pathway to be filled.

PUBLIC HEALTH CONTRACT PERFORMANCE AND QUALITY MANAGEMENT

RESOLVED: 2013/018

(1) That the Quality and Risk Management Policy to Support Health Contracts be endorsed and recommended for approval by Policy Committee.

(2) That the information provided in Public Health Contract Performance and Quality Management be noted, and the format of the proposed report be approved.

WORK PROGRAMME

RSEOLVED: 2013/019

That the Sub-Committee's work programme be noted.

The meeting closed at 3.30 pm.

CHAIR

Nottinghamshire County Council

Report to Public Health Sub-Committee

18 July 2013

Agenda Item: 4

REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND THE CORPORATE DIRECTOR FOR CHILDREN, FAMILIES AND CULTURAL SERVICES

INTEGRATED COMMISSIONING ARRANGEMENTS FOR CHILDREN'S HEALTH SERVICES

Purpose of the Report

1. To provide information on the integrated commissioning arrangements for children's health services in Nottinghamshire, including the establishment of the Nottinghamshire Integrated Commissioning Hub and the governance arrangements for the integrated commissioning of health services for children, young people and families, which were approved by the Children and Young People's Committee on 10 June 2013.

Information and Advice

National and Local Policy Context

2. Commissioning of high quality, effective, integrated children's and maternity health services continues to be a national and local priority, with recognition that commissioning processes for these services are different from those for adults.

3. As a result of the Health and Social Care Act, from 1 April 2013, health services for children in Nottinghamshire are commissioned by an increased number of organisations including six Clinical Commissioning Groups (CCGs), Nottinghamshire County Council (NCC), NHS England Nottinghamshire-Derbyshire Area Team (AT), NHS England South Yorkshire and Bassetlaw AT, Leicestershire-Lincolnshire AT and Public Health England. There is a serious risk of fragmentation of service provision for children.

4. The table overleaf highlights the key national changes in relation to commissioning of services that impact on children and families.

5. Nottingham North and East (NNE) CCG acts as the lead CCG for children and young people in so much as it represents Nottinghamshire County CCGs on the Children's Trust Board and on integrated commissioning groups (ICGs). NNE CCG has been involved in service reviews and scoping projects and leads on the County Health Partnerships contract, which includes a range of children's community services. Bassetlaw CCG is represented on the Children's Trust Board and integrated commissioning groups by the Head of Partnership Commissioning, who is active in commissioning of children's services.

Table 1: Commissioners of maternity and children's health services from 1 April 2013

Topic area/service	**Lead Commissioner**	**Length of time as lead commissioner** (if short term)
Maternity Services	CCGs	
Health Visiting	NHS England Area Teams	2013- 2015
Family Nurse Partnership	NHS England Area Teams	2013- 2015
Immunisation and Vaccination, screening	NHS England Area Teams	
School Nursing	Public Health, NCC	
National Child Measurement Programme (statutory duty)	Public Health, NCC	
Child and Adolescent Mental Health Services (CAMHS)	CCGs	
Services for children with disabilities and complex needs	CCGs	
Paediatric services	CCGs	
Substance use services	Public Health, NCC	
Sexual Health Services (statutory duty)	Public Health, NCC	
Termination of pregnancy services	CCGs	
Population level interventions to reduce and prevent birth defects (with Public Health England)	Public Health, NCC	

Duties and legislation

6. The Children and Families Bill has now passed its second reading in the House of Commons and committee scrutiny of the Bill is beginning. On 5 March 2013, it was announced that the Bill will be amended to place a *legal duty* on CCGs to secure health services that are specified in Education, Health and Care Plans for children with disabilities and special educational needs (SEN). This provides important clarity and reassurance to families in addition to the duties already in the Bill around co-operation and joint commissioning.

7. Public Health within local authorities has a statutory duty to commission a number of services which relate to children and young people including sexual health services and the National Childhood Measurement Programme.

Local Response

8. Following discussions with CCG Chief Officers, senior officers of Nottinghamshire County Council Children, Families and Cultural Services (CFCS) Department , the NHS England Area Teams covering Nottinghamshire and the Children's Trust Board, it was agreed to scope and develop an integrated commissioning function (hub) for children's health services in the County.

9. Prior to April 2013, in the NHS Nottinghamshire County Primary Care Trust (PCT) area, there was no dedicated capacity for commissioning children's health services. Elements of work were led by Public Health, but following the move of Public Health into the Local Authority, this role has changed. Children's services commissioning in Bassetlaw PCT has been part of the role of the Head of Partnership Commissioning who is retained in Bassetlaw CCG.

10. There is recognition that CCGs have limited capacity to take on the commissioning of children's health services. Children's services are complex and interrelated, there is a need for effective working across health, social care and education services and in order to fulfil a number of statutory duties and there are many small, county-wide specialist community NHS and non-NHS services. There is clearly a need for effective joint working across a number of organisations, with sufficient capacity to ensure effective commissioning of services.

11. The rationale for establishing an Integrated Commissioning Hub is summarised below.

Table 2: Rationale for integrated commissioning for children's service

- Whole system approach to planning and commissioning
- Maximise the quality of services for children and their families
- Focus on outcomes
- Reduce silo working and duplication
- Clear processes for engaging with children and families to inform commissioning
- Opportunity to integrate approaches to prevention
- Added value, greater savings, best use of available resources
- Clearer accountability
- Clearer links with recommendations from the Joint Strategic Needs Assessment (JSNA) and other in depth needs assessments to inform commissioning decisions
- In line with the Government's focus on better health outcomes for children.

12. Following discussions referred to above, it was agreed to apply for non-recurrent funding to support the scoping and development of an Integrated Commissioning Hub, to be hosted in the County Council's CFCS Department. CCGs, represented by NNE CCG, NHS England Area Teams and the Local Authority, Nottinghamshire County Council, have agreed this approach.

13. The Integrated Commissioning Hub proposals were presented to the Health and Wellbeing Board on 17 April 2013 as part of the paper on the Health of Vulnerable Children and Young People in Nottinghamshire. Proposals were supported as a positive development. In addition, development of the Hub was approved by the Children and Young People's Committee on 10 June 2013, together with recruitment to identified posts.

Vision for the Integrated Commissioning Hub

14. The Children's Trust Board ambition is reflected in the agreed vision for the Integrated Commissioning Hub:

'We want Nottinghamshire to be a place where children are safe, healthy and happy, where everyone enjoys a good quality of life and where everyone can achieve their potential.

Through integrated commissioning, we will work together with children, young people and their families and use a whole systems approach to improve the planning and commissioning of services for children, young people and their families.'

Model for the Integrated Commissioning Hub

15. The Hub will be a single point of accountability/co-ordination for children's health and well-being related integrated commissioning, on behalf of:

- Nottinghamshire CCGs
- NHS England Area Teams (from April 2015)
- Nottinghamshire County Council, including Public Health.

16. The Hub will consist of a small team, hosted in the County Council's Children, Families and Cultural Services (CFCS) Department. The structure of the team is attached as **Appendix 1** to this report. A number of existing posts currently within the Public Health Directorate will be incorporated into the team and an element of the funding received from all six Nottinghamshire CCGs will be used to recruit to new posts, working in or alongside the integrated commissioning team.

17. New senior posts located in the Integrated Commissioning Hub are detailed below:

- Senior Public Health and Commissioning Manager
- Senior Strategic Performance and Needs Assessment Manager
- Performance and Contracts Officer

18. In addition to these posts, there will be a full time Business Support Administrator and funding has been identified to secure procurement and finance support from the relevant County Council departments. Discussions are underway with the relevant departments in relation to the capacity required to support the Hub team.

19. The Hub will work to align and pool commissioning resources from the County Council, CCGs and the NHS England Area Teams, in some cases via Section 75 arrangements, in order to effectively jointly commission services and activity.

20. The Hub will operate at different commissioning levels depending on the service/topic area. A list detailing this is attached as **Appendix 2.**

21. The Hub will provide opportunities for consistency across services in relation to priorities and processes such as safeguarding children, Pathway to Provision, and young people friendly services.

22. The Hub will be accountable to the Health and Wellbeing Board through the Nottinghamshire Children's Trust Board (membership includes CCGs, CFCS Department, Public Health Department and NHS England Area Teams). In addition it may be appropriate to establish formal direct links with CCGs if agreed. The accountability/governance structure is attached as **Appendix 3**.

Initial scope: areas of commissioning

23. It is envisaged that the Integrated Commissioning Hub takes on the lead for commissioning of children's services in a phased approach and will be operational by September 2013.

24. A full breakdown of initial services considered for inclusion within the scope of the Integrated Commissioning Hub is included in **Appendix 2**. As stated previously, there will be varying levels of commissioning responsibility depending on the particular service. For some services, the Hub will work closely with other agencies that have lead responsibility for a service, while for others, pooled funding and direct commissioning from providers will be in place.

Table 3: Services within the scope of the Integrated Commissioning Hub

- Public health services for children aged 0-5 (breast feeding, Healthy Start Programme)
- Public health services for children and young people aged 5-19 (school nursing, Healthy Schools)
- CAMHS Tiers 1/2/3
- Health services for Looked After Children (CAMHS/nursing/medical)
- Services for children with disabilities and SEN (community services)
- Elements of community paediatrics (where these relate to wider medical safeguarding, LAC and adoption roles, support to schools, disability and SEN services)
- Teenage pregnancy (C-Card Scheme, Teenage Pregnancy Training Programme and links to the commissioning of Contraception and Sexual Health Services)
- Substance use services for young people
- Health services for young offenders in the community

Areas for further/future consideration

25. In due course, and following discussion and agreement of relevant commissioners, it may be appropriate for the Integrated Commissioning Hub to lead on commissioning of general paediatrics (planned and unplanned care), maternity services and continuing care for children and young people. Commissioning responsibility for Health Visiting and the Family Nurse Partnership moves to Nottinghamshire County Council (NCC) from April 2015.

26. Once the Hub is established and following discussion and agreement of commissioners, it may be appropriate for the Integrated Commissioning Hub to lead on commissioning of Nottinghamshire County Council services, for example, commissioning all of disability services together across health, education and social care. This will have an impact on the capacity required and will need to be reviewed in due course.

Governance and accountability

27. The Integrated Commissioning Hub will commission services through a range of joint arrangements as referred to previously. There will be joint working with Nottingham City Council and Nottingham City CCG where there are common populations, common

objectives and in relation to services being provided by the same providers.

28. Governance will be via the Children's Trust to the Health and Wellbeing Board as set out in the diagram in **Appendix 3**. The governance and accountability arrangements were approved by the Children and Young People's Committee on 10 June 2013. The team comprising the Integrated Commissioning Hub will be directly accountable to the Corporate Director for Children, Families and Cultural Services. These arrangements will also ensure appropriate links to the Nottinghamshire Safeguarding Children Board and that robust processes are in place that demonstrate delivery of the relevant statutory duties.

Identified Risks

29. There are a number of risks currently being identified and explored as part of the development of the Integrated Commissioning Hub. A full risk log is under development and will include mitigating factors required to reduce the level of risk associated with the development and delivery of the Integrated Commissioning Hub. The risks can be summarised as follows:

- **Complexity of managing multiple stakeholder views and requirements:** the Integrated Commissioning Hub will have a number of stakeholders including Nottinghamshire County Council Departments, Clinical Commissioning Groups (x6); and the NHS England Area Teams (x2) all of which will have differing views, requirements and priorities.

- **Challenging financial circumstances: financial resources allocated for children and families:** the overall budget allocated to improve the health and wellbeing of children and families and prevent ill health is historically low when compared with that allocated for other groups or for interventions targeted at those in crisis or already in poor health e.g. smoking cessation services, substance use treatment. It is important to ensure that all relevant financial resource is identified, protected as far as possible and used to maximum effect to optimise health outcomes for children, adolescents and in later life.

- **Fragmentation of wider commissioning responsibilities:** there are a number of different commissioner leads responsible for a range of health and other services provided for children, young people and families. The integrated commissioning team will need to understand and influence other commissioners, to ensure that there is a shared understanding of evidence based practice and of local gaps in service delivery. This includes commissioners of services which affect children and young people's outcomes e.g. CFCS Department commissioners, Public Health commissioners for life course areas such as sexual health, smoking, obesity.

Other Options Considered

30. No other options have been considered.

Reason/s for Recommendation/s

31. The Integrated Commissioning Hub is an important opportunity to bring together the commissioning of children's services, an approach which is well established in other

areas. Resources from Clinical Commissioning Groups to pump prime the development have been identified and will support the Hub for three years. Furthermore, the Integrated Commissioning Hub will reduce duplication, streamline commissioning for children services, focus on outcomes, maximise quality whilst ensuring the best use of available resources, embed good practice and enable children, young people and families to have a say in the services and interventions they need.

Statutory and Policy Implications

32. This report has been compiled after consideration of implications in respect of finance, public sector equality duty, human resources, crime and disorder, human rights, the safeguarding of children, the NHS constitution (together with any statutory guidance issued by the Secretary of State) and sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

33. The Integrated Commissioning Hub has been funded for three years from April 2013 to March 2016 by the six Clinical Commissioning Groups in Nottinghamshire and through reallocation of existing staff, by the Public Health Department.

Equalities Implications

34. Due regard has been given to the Public Sector Equality Duty. An Equality Impact Assessment is in progress.

Human Resources Implications

35. The posts have been evaluated and moderated using the County Council's agreed process. Recruitment will be subject to the vacancy control protocol and posts will be available to suitably qualified redeployees.

36. The recognised trade unions were sent a copy of the report and the relevant job descriptions and invited to comment.

Implications related to the NHS constitution and statutory guidance issued by the Secretary of State

37. Regard has been taken to the NHS Constitution together with all relevant guidance issued by the Secretary of State in formulating the recommendation.

RECOMMENDATIONS

That the Public Health Sub-Committee:

1) notes the integrated commissioning arrangements for children's health services, including the establishment of the Nottinghamshire Integrated Commissioning Hub

and governance arrangements for the integrated commissioning of health services for children young people and families.

2) agrees to receive updates in relation to the work of the Integrated Commissioning Hub.

Dr Chris Kenny
Director of Public Health

Anthony May
Corporate Director for Children, Families and Cultural Services

For any enquiries about this report please contact:

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E: kate.allen@nottscc.gov.uk

Constitutional Comments (LM 02/07/13)

38. The Public Health Sub-Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (KLA 01/07/13)

39. The financial implications of the report are set out in paragraph 33 above.

Background Papers and Published Documents

Development of the Integrated Commissioning Function for Children and Young People's Services: A progress report – report to Children's Trust Board on 15 April 2013

Health of Vulnerable Children and Young People in Nottinghamshire – report to Health and Wellbeing Board on 17 April 2013

Integrated Commissioning Arrangements for Children's Health Services - report to Children and Young People's Committee on 10 June 2013

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

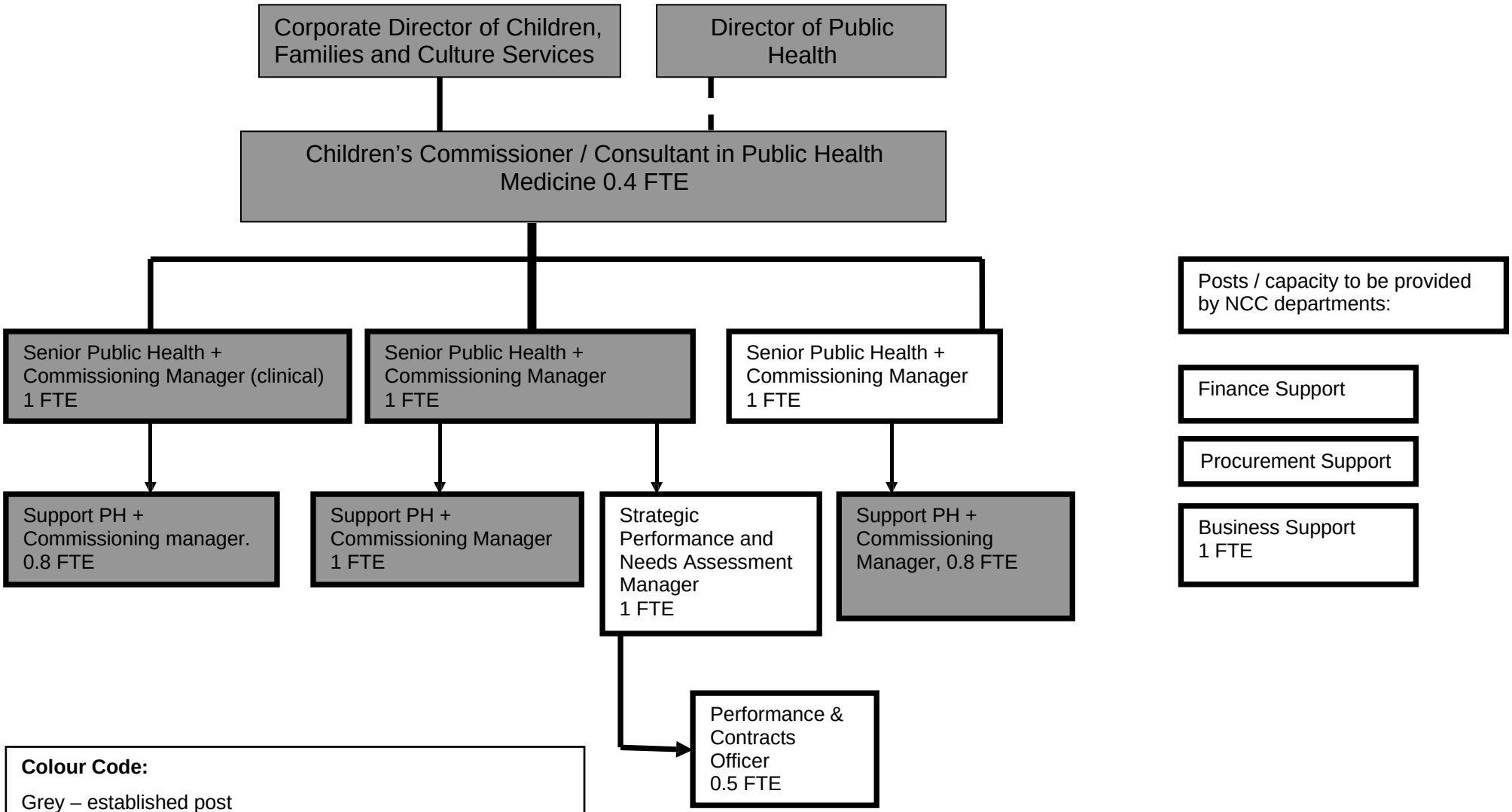
Electoral Division(s) and Member(s) Affected

All.

C0258

Appendix 1

CYP Integrated Commissioning Hub Team Structure

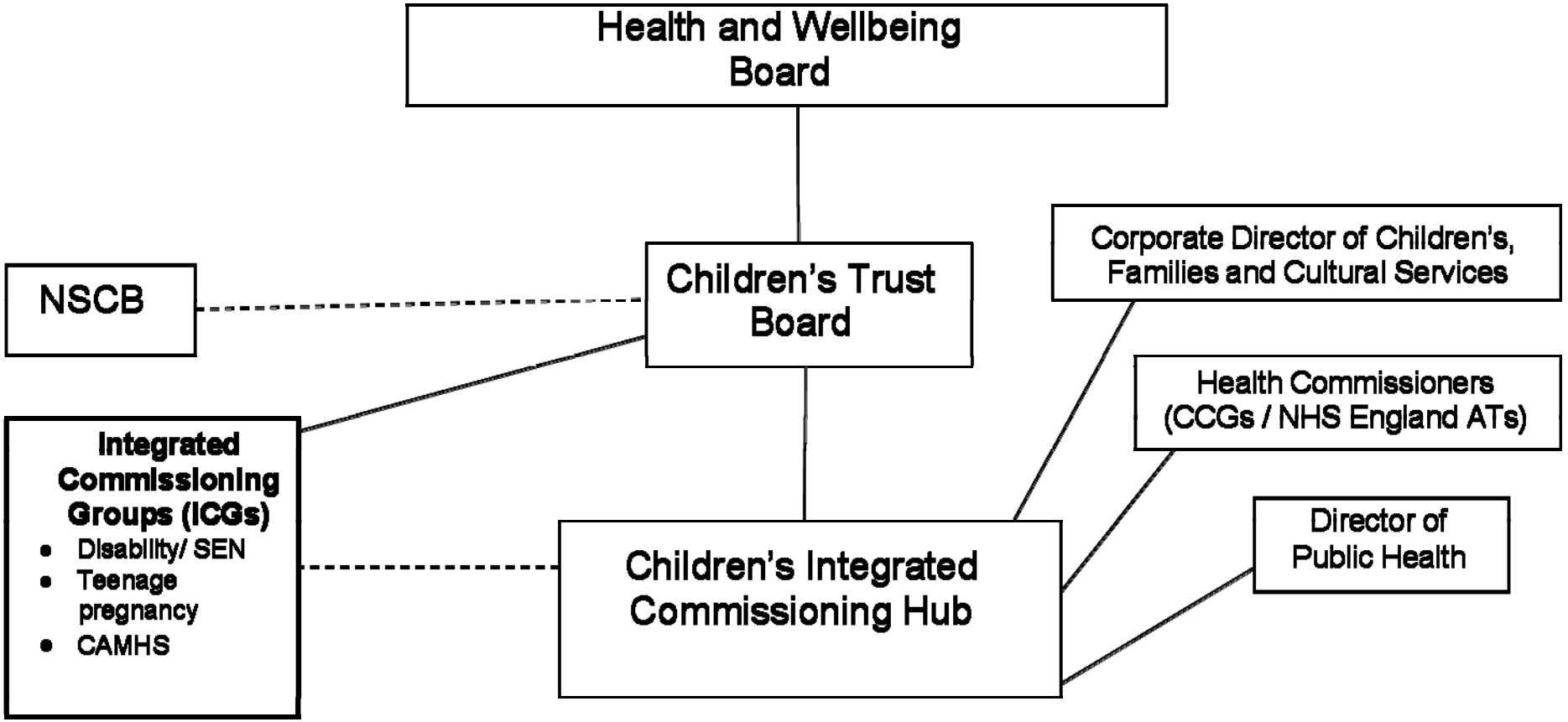


Appendix 2

Commissioning Model	Service/Care Group	Lead Commissioner	Rationale
Co-ordinated – joint development of needs assessment and agreement of shared priorities Individual organisations view these alongside their own priorities Service design, resource allocation, contracting and performance management remain separate	• Paediatric planned care • Paediatric urgent care • Maternity Services	NHS Contracting Teams	These services are "core business" for CCGs Service changes are largely transacted by the contracting teams
	• Health Child Programme 0-5, including Health Visiting • Family Nurse Partnership	NHS England Area Teams (ATs)	These services will be commissioned by the NHS England AT until April 2015, when they move to the Public Health in the LA. Work required to maximise integration with other services and prepare for April 2015
Joint - joint development of needs assessment and agreement of shared priorities Joint agreement of resource allocation and aligning budgets Joint design of service specifications and joint work on procurement/contracting through a lead commissioner CCGs retain responsibility for performance management through agreed contracting and governance arrangements but will require coordination and communication pathways.	• Obesity/Physical Activity/ Nutrition • Drug and Alcohol Services - substance use services for young people • Teenage pregnancy/ sexual health	Public Health/ Integrated Commissioning Hub Elements of sexual health service commissioning transacted via CCG contracting leads initially.	These services will be funded via either the PH Grant or the Local Authority – joint commissioning provides opportunities for increased efficiency Many are already jointly commissioned
	• Community Paediatrics - elements relating to wider medical safeguarding, Looked After Children (LAC) and adoption roles, support to schools, disability and SEN services)	NHS Contracting Teams	These elements are part of the Community Paediatric block contracts with acute providers currently. Full commissioning responsibility may move to Integrated Commissioning Hub if agreed in the longer term.
Integrated – responsibility for the whole commissioning cycle delegated to an integrated team through a pooled budget	• CAMHS Tiers 1/2/3 • Services to meet health	Integrated Commissioning Hub	Potential to make savings through pooling

Commissioning Model	Service/Care Group	Lead Commissioner	Rationale
	needs of disabled children • Services to meet health needs of Looked After Children • All specialist community services for disabled children • Teenage pregnancy (C-Card Scheme, Teenage Pregnancy Training Programme) • Breast feeding support services, Healthy Start programme • Health Child Programme 5-19, including School Nursing • Health services for young offenders in the community	To include formal pooling of budgets via Section 75 agreements	Some services already secured via a joint service specification Proposed changes in legislation (statutory duties) to achieve greater integration between Health, Education and Social Care services. The NHS England Area Teams is lead commissioner for health services for young offenders in custodial settings

Commissioning Model	Service/Care Group	Lead Commissioner	Rationale
National/Regional Commissioning – some services will be commissioned either by NHS England Area Teams (ATs) at a regional level or nationally.	• Primary Care • Screening, I&V • CAMHS Tier 4 • Neonatal/PICU • Tertiary Care • Children's Continuing Care	NHS England Greater East Midlands Commissioning Support Unit	Specialist services commissioned collectively to achieve economies of scale and to maximise quality. Require input from local areas to ensure effective pathways, links between specialised and local services – likely to be provided by Integrated Commissioning Hub


Health and Wellbeing Board
NSCB
Children's Trust Board
Corporate Director of Children's, Families and Cultural Services
Health Commissioners (CCGs / NHS England ATs)
Director of Public Health
Integrated Commissioning Groups (ICGs)
• Disability/ SEN
• Teenage pregnancy
• CAMHS
Children's Integrated Commissioning Hub

Nottinghamshire County Council

Report to the Public Health Sub-Committee

18 July 2013

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

USE OF PUBLIC HEALTH GRANT TO ADDRESS COMMUNITY SAFETY AND VIOLENCE PREVENTION

Purpose of the Report

1. The purpose of this report is to provide a case for Public Health part funding (the remainder being sought from individual Clinical Commissioning Groups) the commissioning of Identification and Referral to Improve Safety (IRIS). £153,000 is sought from the Public Health Grant recurrently.

Information and Advice

Definitions

2. The Home Office (2013) defines domestic violence and abuse (DVA) as:

   "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

3. IRIS is a domestic violence training, support and referral programme for general practice staff. It is a targeted intervention for female patients aged 16 and above who are experiencing or who have experienced domestic violence and abuse from a partner, ex-partner or family member.

Context

4. Domestic abuse is an indicator in Domain 1: Improving the wider determinants of health of the Public Health Outcomes Framework.

5. Domestic violence and abuse has been identified as a priority for action for the Safer Nottinghamshire Board, the Nottinghamshire Health & Wellbeing Strategy and for the recently elected Police and Crime Commissioner. Further to this the Mandate[i] from the government to the NHS England cites the broader role of the NHS in society is to work in

partnership to contribute to reducing violence, in particular by improving the way the NHS shares information about violent assaults with partners and supports victims of crime.

6. Following obtaining the support of the Health and Wellbeing Board in January 2013 (appendix 1) Clinical Commissioning Groups have begun to engage in and plan for the implementation of IRIS across general practice. Mansfield and Ashfield CCG have made the most progress and are currently tendering for a service provider.

The Rationale

7. Domestic violence and abuse is common. The majority of DVA incidents or victims remain hidden, i.e. they are not disclosed to authorities. However, it is possible to estimate the numbers of victims by applying the findings of the British Crime Survey 2011/12 to the Nottinghamshire population and this is shown in Table 1.

Table 1: Estimated Number of Female Victims of Domestic Violence in Nottinghamshire (16-59 years of age)[ii]

Period	Percentage	Numbers
Across their lifetime	29 - 32	66,410 and 73,280
In the last year	7 - 11	16,030 and 25,190

8. Whilst DVA occurs across all sections of society, men are far more likely to be the perpetrators and women the victims. Women are also more likely to experience repeated and severe forms of violence, including sexual violence and are also more likely to have sustained psychological or emotional impact or result in injury or death[iii]. Consequently DVA causes an inequality in ill health amongst women. Survivors of DVA can have chronic health problems including: gynaecological disorders, chronic pain, neurological symptoms, gastro-intestinal disorders, and self-reported heart disease[iv]. The most prevalent effect is on mental health, including post-traumatic stress disorder, depression, anxiety, suicidal thoughts, and substance misuse[v].

The IRIS Service

9. The IRIS service comprises of:
   - *A named Advocate Educator:* linked to the practice and based in a specialist domestic violence and abuse service. The Advocate Educator acts as a consultant to the practice team and is the person to whom patients wanting support are directly referred.

   - *Training and support*: each medical practice receives in-house training and ongoing support. Clinician training focuses on identification of DVA through clinical enquiry and appropriate response, referral and recording. Training for reception and administration teams focuses on understanding DVA, data handling, confidentiality and safety.

   - *Electronic prompt*: This appears in the patient medical record in the form of a pop-up template triggered by read-coded symptoms and conditions associated with DVA. The electronic prompt is a reminder to ask and record data about DVA.

   - *Health education resources*: posters about DVA are put up in practices and cards provided for patients. Practices receive referral forms and care pathways for female survivors, male victims and perpetrators.

- *Named contact for patient referrals* - practice staff can refer directly by phone, fax or email to the Advocate Educator.

- *Advocacy for patients* – an Advocate Educator provides patients with emotional and practical support and carries out risk assessments and safety plans. The Advocate Educator acts as a triage and brokering service, signposting patients into other services as necessary.

Expected Outcomes

10. The IRIS approach aims to increase identification of victims of DVA in primary care and provide primary care practitioners with the skills and tools to respond to, refer on and record disclosures of DVA from their patients.

11. General Practice can play an instrumental role in responding to and preventing further domestic violence. Implementing this approach will lead to:
    - increased case findings
    - improved support available sooner,
    - improved patient safety
    - reduction in recurrence of DVA
    - reduction in safeguarding issues
    - improvement in the quality of care for patients.

12. The IRIS approach has proven to be cost effective and possibly a cost saving intervention in general practice.

Other Options Considered

13. **Maintain the status quo.** This option would not equip practice staff with the skills specified in section 9 nor secure the outcomes identified in section 10 above.

14. **Provide match funding to one CCG or a few practices as a pilot.** The IRIS approach has been subject to a randomised controlled trial following which Nottinghamshire has secured support with local implementation from the national IRIS team (which is not available to all areas pending review of the national team's capacity and resources). Providing IRIS on a smaller scale would be less efficient and would not address the issues to do with equity outline in section 7 and 8.

Statutory and Policy Implications

15. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications related to the NHS constitution (together with any statutory guidance issued by the Secretary of State)

16. Regard has been taken to the NHS Constitution together with all relevant guidance issued by the Secretary of State in formulating the recommendation.

Implications for Service Users

17. Improvement in and consistency of the response from general practice to the identification of and support made available to people experiencing domestic violence and abuse.

Financial Implications

18. Implementation of IRIS across Nottinghamshire has first year costs totalling £313,000. A total of £153,000 recurrent funding is sought from the Public Health grant so as to part fund the intervention. The remaining costs will be funded from the CCGs. Public Health does not currently commit any other finance towards domestic violence prevention and reduction in primary care.

RECOMMENDATION

1. That the Public Health Sub-Committee are asked to:

   Approve £153,000 of Public Health Funding recurrently to part fund the implementation of IRIS across the county.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Nick Romilly Public Health Manager
nick.romilly@nottscc.gov.uk Tel 01623 433038

Constitutional Comments (SG 20/06/2013)

19. The Committee has responsibility for Public Health under its Terms of Reference and is the appropriate body to decide the issues set out in this report.

Financial Comments (ZKM 03/07/2013)

20. The financial implications of this report are outlined in paragraph 18.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

[1] Department of Health (2012) The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 www.dh.gsi.gov.uk/mandate

[1] Hall P and Smith K (2011) Analysis of the 2010/11 British Crime Survey Intimate Personal Violence split sample experiment. Home Office July 2011 accessed November 2012 http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/analysis-bcs-ipv-2011?view=Binary and http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Age+and+Sex

[1] Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime In England and Wales 2007/08) London: Home Office

[1] Feder,G et al (2011). Identification and Referral to Improve Safety of women experiencing Domestic Violence with a primary care training and support programme: a cluster randomised controlled trial. The Lancet October 13.

[1] Coid, J et al (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal Psychiatry* 2003: **183**; 332-39

Electoral Division(s) and Member(s) Affected All

[i] Department of Health (2012) The Mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 www.dh.gsi.gov.uk/mandate

[ii] Hall P and Smith K (2011) Analysis of the 2010/11 British Crime Survey Intimate Personal Violence split sample experiment. Home Office July 2011 accessed November 2012 http://www.homeoffice.gov.uk/publications/science-research-statistics/research-statistics/crime-research/analysis-bcs-ipv-2011?view=Binary and http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Age+and+Sex

[iii] Povey D, Coleman K, Kaiza P and Roe S (2009) Homicides, Firearm Offences and Intimate Violence 2007/08 (Supplementary Volume 2 to Crime In England and Wales 2007/08) London: Home Office

[iv] Feder,G et al (2011). Identification and Referral to Improve Safety of women experiencing Domestic Violence with a primary care training and support programme: a cluster randomised controlled trial. The Lancet October 13.

[v] Coid, J et al (2003). Abusive experiences and psychiatric morbidity in women primary care attenders. *British Journal Psychiatry* 2003: **183**; 332-39

Nottinghamshire County Council

Report to the Public Health Sub-Committee

18 July 2013

Agenda Item: 6

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

USE OF PUBLIC HEALTH GRANT TO COMMISSION SUICIDE PREVENTION TRAINING

Purpose of the Report

1. The purpose of this report is to make the case for £35,000 of the Public Health Grant to be used recurrently to commission Suicide Prevention Training.

Information and Advice

Context

2. Suicide is an indicator in Domain 4: healthcare public health and preventing premature mortality of the Public Health Outcomes Framework.

3. Mental health and emotional wellbeing is a priority in the Health and Wellbeing strategy. The Government's policy is ensuring that mental health has equal priority with physical health, and this needs to be reflected locally. Therefore additional funds are requested to support work on suicide prevention.

4. Currently there is no suicide prevention training taking place to support health professionals in primary care to encourage early identification and intervention of 'at risk' individuals.

5. Based on the provision of Suicide Prevention Training delivered historically in Nottinghamshire, a recurrent £35,000 would commission a part time suicide prevention training programme which could be tailored to a target audience of primary care and other health professionals. The Nottingham City and County Suicide Prevention Strategy and action plan is currently being refreshed. Via this work stream, match funding will be sought in Nottingham City so as to jointly commission Suicide Prevention Training.

Rationale

6. For men under 35, suicide is the most common cause of death and men are three times more likely than women to take their own lives. Overall, people aged 40-49 have the highest suicide rate. Nottinghamshire has a lower overall rate of death by suicide than the England average, but a higher rate of suicides in people over 75.

7. The national strategy preventing suicide in England (2012) identifies Suicide Prevention Training as an effective local intervention:

"Appropriate training on suicide and self-harm should be available for staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems (p17)."

8. The World Health Organisation recommends that providing training to GPs in early identification and intervention for those at risk of suicide is an effective strategy in suicide prevention.[1]

Expected Outcomes

9. There is evidence that the provision of Suicide Prevention Training in health settings is effective in raising awareness and providing healthcare professionals with the necessary skills to identify patients at risk of suicide[2]. The principle outcome is to ensure professionals are aware of effective interventions and where to refer patients when there is a concern. In the longer term, the expectation is that this intervention will contribute towards a reduction in the number of suicides.

10. The cost-effectiveness of provision of suicide awareness training to GPs has been modelled based on the assumption that improvements in identification of those at risk leads to reductions in suicide[3]. This has concluded that investment in GP Suicide Prevention Training is cost effective from the first year of investment and that even with conservative assumptions made about the gains in life overall and in the quality of life, the cost per QALY (Quality Adjusted Life Year) saved is £1,573 over one year, rising to £2004 over 5 years.

Suicide Prevention Training

11. Suicide Prevention Training would comprise of - recognition, assessment and management of risk, warning signs associated with suicide intention, the links between self-harm and suicide, effective interventions and roles and responsibilities of healthcare staff.

12. The provider of the Suicide Prevention Training and how it would be implemented would be determined by a tender process and commissioned jointly with Nottingham City.

Other Options Considered

13. Maintain the status quo. This option would not equip primary care staff with the necessary skills nor achieve the expected outcomes specified in section 9 above.

Statutory and Policy Implications

Financial Implications

14. The financial implication is that £35,000 of the Public Health Grant would be allocated recurrently to commission Suicide Prevention Training across the County.

[1] WHO (2010) Towards evidence-based suicide prevention programmes http://www.wpro.who.int/publications/PUB_9789290614623/en/index.html

[2] Wood S, Bellis MA, Mathieson J, Foster K. 2010. Self harm and suicide: A review of evidence for prevention from the UK focal point for violence and injury prevention. Centre for Public Health, Liverpool John Moores University, September 2010. http://www.cph.org.uk/UserFiles/File/Epidemiology/safety2010/selfharm-suicide.pdf. Isaac M, Elias B, Katz L Y, Belik S, Deane FP, Enns M W, Sareen J. 2009. Gatekeeper training as a preventative intervention for suicide: A systematic review. Canadian Journal of Psychiatry-Revue Canadienne de Psychiatrie, 54 (4), 260-268. Morriss R, Gask L, Webb R, Dixon C and Appleby I. 2005. The effects on suicide rates of an educational intervention for front-line health professionals with suicidal patients (the STORM Project). Psychological Medicine, 35

[3] Knapp M, McDaid D, Parsonage M (Eds). Mental health promotion and mental illness prevention: The economic case. http://www.centreformentalhealth.org.uk/pdfs/Economic_case_for_promotion_and_prevention.pdf

Safeguarding Implications

15. A substantial proportion of people who commit suicide die without having seen a mental health professional[4]. Hence improved detection, referral and management of psychiatric disorders in primary care is an important step in suicide prevention and safeguarding a vulnerable group.

Implications related to the NHS constitution (together with any statutory guidance issued by the Secretary of State)

16. Regard has been taken to the NHS Constitution together with all relevant guidance issued by the Secretary of State in formulating the recommendation.

RECOMMENDATION/S

That the Public Health Sub-Committee are asked to:

1. Approve a recurrent £35,000 of the Public Health Grant to commission Suicide Prevention Training across the county.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact Nick Romilly,Public Health Manager nick.romilly@nottscc.gov.uk or 01623 433038

Constitutional Comments (SG 24/06/2013)

17. The Committee has responsibility for Public Health under its Terms of Reference and is the appropriate body to decide the issues set out in this report.

Financial Comments (ZKM 03/07/2013)

18. The financial implications of this report are outlined in paragraph 17.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

See footnotes

Electoral Division(s) and Member(s) Affected

All

[4] WHO (2000) Preventing Suicide a resource for General Physician. Dept of Mental Health WHO Geneva

Nottinghamshire County Council

Report to the Public Health Sub-Committee

18 July 2013

Agenda Item: 7

REPORT OF DIRECTOR OF PUBLIC HEALTH

COMMUNITY INFECTION PREVENTION & CONTROL

Purpose of the Report

1. Approval of the Public Health Sub-Committee is requested for a project to review the provision of Community Infection Prevention and Control in Nottinghamshire County and implement arrangements for the period 2015 and beyond, including any procurement work which may be required to identify preferred provider(s).

Information and Advice

2. Community Infection Prevention and Control (CIPC) refers to the prevention of infections in people receiving care in either health or social care settings in the community, such as GP practices or care homes. Prevention includes ensuring a combination of good hygienic practice, careful use of antibiotics and improved techniques and devices.

3. Upper tier local authorities have been delegated responsibility for funding Community Infection Prevention and Control, to be funded out of the Public Health grant received by Nottinghamshire County Council.

4. Current arrangements in Nottinghamshire County (and in other areas across England) are inconsistent and need improving.

5. A Project Initiation Document has been drafted which sets out the scope and governance of the proposed project.

6. The progress of the project will be monitored by the Health Protection Strategy Group, chaired by Dr Chris Kenny, Director of Public Health.

7. Assuming satisfactory progress, a recommendation report will be brought to the Public Health Subcommittee in 2014 to request approval for the award of contract to the preferred provider(s). Subject to the agreement of the Subcommittee, there will be no requirement to seek further approval from the Subcommittee prior to submission of the Recommendation report.

8. A similar review of CIPC arrangement is required in Nottingham City. Therefore the project will address the needs of Nottingham City and Nottinghamshire County. This will allow exploration of whether additional value might be secured through a joint approach to

procurement of the future service(s). Approval of recommended solutions for Nottinghamshire County shall remain the sole responsibility of the Nottinghamshire County Public Health Subcommittee. Approval of recommendations for Nottingham City shall remain the sole responsibility of Nottingham City Council.

Other Options Considered

9. "Do nothing"

   There is currently no robust permanent arrangement in Bassetlaw, and arrangements for the rest of the County lack sufficient capacity on which to provide proper assurance about their resilience and impact.

10. "Decide to provide CIPC using in-house resource (with or without additional capacity to ensure resilience and impact)"

    This would avoid the one-off transactional costs associated with a procurement exercise. However, in-house provision is not without problem (e.g. professional isolation for specialists). Furthermore, one would forego the benefit of consulting the market and of testing out what is best value through a competitive procurement process. As a result it would be difficult to assure the Subcommittee that the solution represents best value. Therefore we recommend that in-house provision is properly considered alongside outsourced options.

Reason/s for Recommendation/s

11. A review of the requirements and procurement options for provision of CIPC beyond 2015 will provide a reasonable basis on which to advise the Subcommittee about future arrangements.

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The cost of the recommendation to be brought to the committee will be funded from within the public health grant. In advance of the needs assessment and procurement activity, the cost of meeting the future needs of Nottinghamshire County residents can only be estimated. The current allocation for CIPC in the public health grant is £160,000 pa. This appears to reflect levels of expenditure since the service was cut back by the former Nottinghamshire County PCT in 2011. As noted in paragraph 9, these current arrangements are neither robust nor comprehensive in their coverage.

Implications for service users and Human Resources Implications

14. Implications for service users relate to changes in the level of protection they experience from healthcare associated infection. There will be implications for the current workforce if it is determined that best value will be secured from a service model in which the CIPC function is provided by another organisation.

RECOMMENDATION/S

1) Approve the request for a project to review the provision of Community Infection Prevention and Control in Nottinghamshire County and implement arrangements for the period 2015 and beyond, including any procurement work which may be required to identify preferred provider(s).

Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Jonathan Gribbin, Consultant in Public Health

Constitutional Comments (SG 24/06/2013)

15. The Committee has responsibility for Public Health under its Terms of Reference and is the appropriate body to decide the issues set out in this report.

Financial Comments (ZKM 03/07/2013)

16. The financial implications of this report are outlined in paragraphs 13 and 14.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Project Initiation Document - Review Provision of Community Infection Prevention & Control.

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to the Public Health Sub-Committee

18 July 2013

Agenda Item: 8

REPORT OF THE DEPUTY DIRECTOR OF PUBLIC HEALTH

NHS HEALTH CHECK COMMISSIONING AND IMPLEMENTATION PLAN

Purpose of the Report

1. This report builds on the Public Health Service Developments Report approved by PH Sub-Committee on 22nd April 2013. It details the proposed plan for commissioning and implementation of the NHS Health Check Programme for the period 2013-2015 and sets the direction for the ongoing rolling programme beyond 2015.

2. It includes the pre-committed funding for this year and the service development proposal requiring additional funding (see below - Financial Implications).

Information and Advice

3. The NHS Health Check is a national risk assessment and prevention programme that identifies people at risk of developing cardiovascular diseases (CVD) e.g. heart disease, stroke, diabetes, kidney disease or certain types of dementia, and helps them take action to avoid, reduce or manage their risk of developing these conditions.

4. NHS Health Checks are aimed at everyone between 40 and 74 years of age excluding those who have been previously diagnosed with a cardiovascular condition or are being treated for certain risk factors such as high blood pressure or high cholesterol.

5. CVD is responsible for a third of deaths and a fifth of hospital admissions and accounts for the largest element of health inequalities. The NHS Health Check consists of a risk assessment and risk reduction actions, which can include a referral to lifestyle or clinical interventions. NICE guidance is the basis for both aspects of the programme. Risk assessment is the responsibility of the council, whilst risk reductions actions are a shared responsibility of councils (lifestyle interventions) and Clinical Commissioning Groups (clinical interventions).

6. It is estimated that the programme will save £57 million per year from the NHS budget, rising to £176 million per year after fifteen years. It is likely that there will be significant additional social care savings as a result of ill health prevention e.g. fewer people requiring social care with CVD-related disability.

7. The NHS Health Check is one of the three mandatory functions which are included in the Health and Social Care Act 2012, and is one of nine interventions featured in Living Well for

Longer, a call to action to improve cardiovascular outcomes launched by the Secretary of State for Health in Spring 2013. The Local Government Association and Public Health England state that Health and Wellbeing Boards should ensure that NHS Health Check is reflected in commissioning plans stemming from the Health and Wellbeing Strategy.

8. Local authorities have a legal duty to seek continuous improvement in the percentage of individuals taking up the offer of a Health Check, as part of their statutory duties. The number of offers made and the number of health checks received must be monitored by councils; both measures are indicators within the Public Health Outcomes Framework for England 2013-2014.

Other Options Considered

9. The following options for the commissioning and implementation of the NHS Health Check were considered:

    1) Recommission the current service delivered by GPs with increased funding to provide incentives for delivery to targets

    2) Recommission the current service without any increase to funding

    3) Commission services according to the proposed model without an increase to funding

    4) Commission services according to the proposed model with an increase to funding to ensure complete coverage of the eligible population, with adequate uptake to ensure the clinical and cost effectiveness of the programme

Reason/s for Recommendation/s

10. The higher the coverage and take up, the greater the impact of the programme and the more likely it is to tackle health inequalities. By logical extension, the higher the coverage and take up, the more likely it is also to achieve the long term cost savings suggested by the economic modelling. Extending delivery to target and promote take up within high risk groups is particularly important in this respect.

11. Option 4 is the recommended approach. Details of this option are in the background paper, but briefly it consists of four strands:
    1. Core service – continuation of delivery by GP practices
    2. Outreach service – additional suppliers to engage high risk and hard to engage groups
    3. Social marketing – to increase uptake
    4. IT infrastructure – to permit ongoing performance management and quality assurance.

    The intention is that all strands will be commissioned jointly with Nottingham City Public Health, except the core service if this is appropriate for Direct Award. Staff leading on NHS Health Checks for both organisations are accountable to Nottinghamshire County Public Health.

12. National economic modelling, undertaken prior to introduction of the NHS Health Check, showed the programme to be extremely cost effective. The parameters for the modelling assumed full coverage, high take up rates, and programme funding commensurate with this option.

13. Option 4 will enable sufficient capacity to be commissioned, with incentives for suppliers to achieve the coverage and uptake needed to match the cost-effectiveness of the national model, as well as realising the significant health benefits.

14. Option 4 will support the linkage of the NHS Health Check programme with workplace health i.e. delivery of NHS Health Checks in the workplace as part of the Nottinghamshire Wellbeing at Work Scheme.

15. Option 1 is based on the pre-existing Local Enhanced Services (NHS GP contract) agreement. The Local Government Association and Public Health England state, "it is not suitable to simply continue contracts on the basis of pre-existing Locally Enhanced Services agreements."

16. Options 1 and 2: Councils are required to plan to invite all their eligible population over a five year rolling cycle. The initial cycle finishes on 31st March 2015 and these options – delivery by primary care alone - are unlikely to meet this requirement due to capacity constraints and barriers to reaching hard to engage population groups. In 2012-2013 19% of the eligible Notts PCT population was offered a health check against a target of 25% coverage for the year, and 51% of these took up the offer (37,622 offers and 19,301 checks completed). In Nottingham City, coverage was 22% (20,212 offers) and uptake was 42% (8,445 checks completed). [Performance data for Bassetlaw are unavailable because the contract with Bassetlaw practices used a paper reporting system for invoicing purposes, without enabling benchmarking at PCT level; implementation of the IT toolkit will resolve this.]

17. Additionally, evidence from the local NHS Health Check Report Years 1 and 2 suggests that this delivery model for Options 1 and 2 has the potential to increase health inequalities, because people in less deprived quintiles and younger age groups were more likely to take up the core offer from their GP.

18. Options 2 and 3 are unlikely to achieve full coverage over the five year cycle, and likely to entail failure to fulfil the council's legal duty to seek continuous improvement in uptake. The Nottinghamshire programme was purposely slowed down in 2011-12 to contribute £0.5 million to the PCT Quality Innovation Productivity and Prevention initiative (QIPP) on the understanding that there would be a subsequent catch-up by April 2015, therefore the additional funding is required to accelerate the programme to meet our commitments. The risk of funding shortfall leading to failure to achieve full coverage with an effective level of uptake (75% is recommended by Public Health England) has been highlighted as Very High on the council's Public Health Risk Register.

Statutory and Policy Implications

19. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications for Service Users

20. The proposed plan will make the programme more accessible by extending delivery and access beyond health clinics and GP practices. It will also ensure that people with higher risk of developing cardiovascular diseases are identified and targeted.

Financial Implications

The proposed plan will require funding from the Public Health Grant, as follows:

Pre-committed	GP delivery	Recurrent	£859,221
	IT toolkit		£30,000
Additional	IT core engine	Recurrent	£31,525
	Outreach service delivery		£396,200
	Targeted social marketing		£32,000
	Social market research & campaign development	Non-recurrent	£50,000

21. Additional funding requirements are therefore:

Recurrent	£459,725	
Non-recurrent	£ 50,000	
Total	£509,725	(Total recurrent programme cost = £1,348,946)

Equalities Implications

22. As part of the process of making decisions and changing policy, public authorities are required by law to think about the need to
    a. Eliminate unlawful discrimination, harassment and victimisation.
    b. Advance equality of opportunity between people who share protected characteristics (as defined by equalities legislation) and those who don't.
    c. Foster good relations between people who share protected characteristics and those who don't.

    Equality Impact Assessments (EIAs) are a means by which a public authority can assess the potential impact that proposed decisions / changes to policy could have on the community and those with protected characteristics. They may also identify potential ways to reduce any impact that a decision / policy change could have. If it is not possible to reduce the impact, the EIA can explain why. Decision makers must understand the potential implications of their decisions on people with protected characteristics.

    An EIA has been undertaken and is available as a background paper. Decision makers must give due regard to the implications for protected groups when considering this report.

23. A full Health Equity Audit is being undertaken for completion by August 2014 and will inform ongoing programme development.

Implications for Sustainability and the Environment

24. The introduction of an outreach service should reduce travelling by private transport e.g. workplace and community health check clinics would negate the need for employees to make a separate trip to their GP practice.

RECOMMENDATION/S

It is recommended that Public Health Sub-Committee:

1) supports the proposed NHS Health Check Commissioning and Implementation Plan (Option 4)

2) receives an update on the NHS Health Check Commissioning and Implementation Plan following procurement.

JOHN TOMLINSON
DEPUTY DIRECTOR OF PUBLIC HEALTH

For any enquiries about this report please contact: Helen Scott, Senior Public Health Manager helen.scott@nottscc.gov.uk 01623 433209

Constitutional Comments (SG 09/07/2013)

25. The Sub-Committee is the appropriate body to decide the issues set out in this Report. By virtue of its Terms of Reference, the Sub-Committee has responsibility for Public Health with the exception of functions reserved to the Health and Wellbeing Board.

Financial Comments (ZKM 24/06/13)
26. The financial implications are outlined in paragraphs 20 and 21 of this report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- Public Health Service Developments (Report to Public Health Subcommittee 16th April 2013)
- NHS Health Check Commissioning and Implementation Plan 2013-2015
- Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/351/regulation/4/made
- NHS Health Check Frequently Asked Questions, Local Govt Association and Public Health England, May 2013
- Living Well for Longer: A call to action to reduce avoidable premature mortality http://livinglonger.dh.gov.uk/2013/03/04/mortality-call-to-action/
- NHS Health Check Report Years 1 and 2 (Public Health Reports, NHS Nottinghamshire County, 2012)

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Public Health Sub-Committee

18 July 2013

Agenda Item: 9

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Sub-Committee's work programme for 2013/14.

Information and Advice

2. The County Council requires each committee or sub-committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chair, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

4. As part of the transparency introduced by the revised committee arrangements in 2012, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the sub-committee will wish to commission periodic reports on such decisions. The sub-committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme.

Other Options Considered

5. None.

Reason/s for Recommendation/s

6. To assist the committee in preparing its work programme.

Statutory and Policy Implications

7. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the sub-committee's work programme be noted, and consideration be given to any changes which the sub-committee wishes to make.

Jayne Francis-Ward
Corporate Director, Policy, Planning and Corporate Services

For any enquiries about this report please contact: Paul Davies, x 73299

Constitutional Comments (HD)

1. The Sub-Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (PS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Public Health Sub-Committee Work Programme 2013/14

Meeting Dates	PH Sub Committee	Lead Officer	Supporting Officer
18 July 2013	Development of the Integrated Commissioning Hub for children and young people's health services	Kate Allen	Irene Kakoulis
	Follow up report on NHS Health Checks	John Tomlinson	Helen Scott
	Follow up report on Domestic Violence	Barbra Brady	Nick Romilly
	Follow up report on Suicide Prevention	Barbra Brady	Nick Romilly
	Community Infection Prevention & Control	Jonathan Gribbin	
12 September 2013	Public Health Nursing	Kate Allen	Irene Kakoulis
	Substance Misuse report incorporating: • Half Year report on prisons Substance Misuse Services • Follow up report on substance misuse commissioning (*incorporating request for delegated authority to approve the tender results for community based SMS services*.)	Barbara Brady	Tammy Coles
	Follow up report on Tobacco Control funding	John Tomlinson	Lindsay Price
	Follow up report on Work Place Health	Penny Spring	Cheryl George
	Draft PH Business Plan	Cathy Quinn	Sally Handley
	Annual Performance and Finance Report for 2012-13 & Performance and Finance Report for April-June 2013	Cathy Quinn	Sally Handley
7 November 2013	Follow up report on Obesity commissioning TBC	Barbara Brady	Anne Pridgeon
	Family Nurse Partnership TBC	*Kate Allen*	
9 January 2014	Performance and Finance Report for July – Sept 2013	Cathy Quinn	Sally Handley
6 March 2014	Performance and Finance Report for Oct - Dec 2013	Cathy Quinn	Sally Handley

Updated: 28 June 2013

8 May 2014	Performance and Finance Report for Jan-Mar 2014	Cathy Quinn	Sally Handley
3 July 2014			

Proposed Future Items (& suggested date)

- Procurement plan for retendering PH services
-